		FOR OHF USE					

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0013862

Facility Name: ST JOSEPH HOME OF PEORIA

Address: 2223 West Heading Avenue (Number) West Peoria (City) 61604 (Zip Code)

County: Peoria

Telephone Number: (309) 673-7425 **Fax #** (309) 673-7430

IDPA ID Number: 37-0676431

Date of Initial License for Current Owners: unknown

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code	501C3		Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Sister Mary Dries **Telephone Number:** (309) 673-7425

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/2001 to 06/30/2002 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) 09/27/2002 (Date)
(Type or Print Name) Sister Mary Dries
(Title) Co-Administrator

Paid Preparer

(Signed) (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number ST JOSEPH HOME OF PEORIA # 0013862 Report Period Beginning: 07/01/2001 Ending: 06/30/2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	43	Intermediate (ICF)	43	15,695	3
4		Intermediate/DD			4
5	146	Sheltered Care (SC)	146	53,290	5
6		ICF/DD 16 or Less			6
7	189	TOTALS	189	68,985	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	6,071	8,939		15,010	10
11	ICF/DD					11
12	SC	9,113	29,234		38,347	12
13	DD 16 OR LESS					13
14	TOTALS	15,184	38,173		53,357	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.35%

D. How many bed-hold days during this year were paid by Public Aid?
9 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started November 1958

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [N/A] NO [ ]

Tax Year: _____ Fiscal Year: 06/30

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number ST JOSEPH HOME OF PEORIA # 0013862 Report Period Beginning: 07/01/2001 Ending: 06/30/2002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger: Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary			805,142	805,142		805,142	(84,671)	720,471			1
2	Food Purchase											2
3	Housekeeping	357,219	37,390	24,928	419,537		419,537	(17,124)	402,413			3
4	Laundry											4
5	Heat and Other Utilities			169,423	169,423		169,423	(9,893)	159,530			5
6	Maintenance	88,397	18,338	22,913	129,648		129,648		129,648			6
7	Other (specify):*											7
8	**TOTAL General Services**	445,616	55,728	1,022,406	1,523,750		1,523,750	(111,688)	1,412,062			8
	B. Health Care and Programs											
9	Medical Director			400	400		400		400			9
10	Nursing and Medical Records	1,391,263	44,903	342,199	1,778,365		1,778,365	(218,906)	1,559,459			10
10a	Therapy	22,193		1,036	23,229		23,229		23,229			10a
11	Activities	49,508	7,191	15,767	72,466		72,466		72,466			11
12	Social Services	11,447			11,447		11,447		11,447			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,474,411	52,094	359,402	1,885,907		1,885,907	(218,906)	1,667,001			16
	C. General Administration											
17	Administrative			65,117	65,117		65,117		65,117			17
18	Directors Fees											18
19	Professional Services			21,721	21,721		21,721	(20)	21,701			19
20	Dues, Fees, Subscriptions & Promotions			12,991	12,991		12,991	(9,965)	3,026			20
21	Clerical & General Office Expenses	45,670	9,396	22,117	77,183		77,183	(4,765)	72,418			21
22	Employee Benefits & Payroll Taxes			367,533	367,533		367,533	(43,112)	324,421			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,347	1,347		1,347		1,347			24
25	Other Admin. Staff Transportation			3,246	3,246		3,246	(1,640)	1,606			25
26	Insurance-Prop.Liab.Malpractice			27,845	27,845		27,845		27,845			26
27	Other (specify):*	24,187	26,091	24,200	74,478		74,478	(74,478)				27
28	**TOTAL General Administration**	69,857	35,487	546,117	651,461		651,461	(133,980)	517,481			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,989,884	143,309	1,927,925	4,061,118		4,061,118	(464,574)	3,596,544			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number ST JOSEPH HOME OF PEORIA #0013862 Report Period Beginning: 07/01/2001 Ending: 06/30/2002

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation											30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* **Depreciation**			134,963	134,963		134,963	(6,477)	128,486			36
37	**TOTAL Ownership**			134,963	134,963		134,963	(6,477)	128,486			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops	17,532	41,236		58,768		58,768		58,768			41
42	Provider Participation Fee			23,543	23,543		23,543		23,543			42
43	Other (specify):* **Sisters' Maintenance**			2,226	2,226		2,226	(2,226)				43
44	**TOTAL Special Cost Centers**	17,532	41,236	25,769	84,537		84,537	(2,226)	82,311			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,007,416	184,545	2,088,657	4,280,618		4,280,618	(473,277)	3,807,341			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number ST JOSEPH HOME OF PEORIA # 0013862 Report Period Beginning: 07/01/2001 Ending: 06/30/2002

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	6,130	27		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions	6,477	36		15
16	Personal Expenses (Including Transportation)	1,640	25		16
17	Non-Care Related Fees				17
18	Fines and Penalties	18,070	27		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	20	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	57,161	20, 27		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	4,394	20		28
29	Other-Attach Schedule	375,932	See H		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 469,824		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 469,824		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

ST JOSEPH HOME OF PEORIA

ID# 0013862

Report Period Beginning: 07/01/2001

Ending: 06/30/2002

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ST JOSEPH HOME OF PEORIA # 0013862 Report Period Beginning: 07/01/2001 Ending: 06/30/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	20	0	0	0	0	0	0	0	0	0	0	20	19
20	Fees, Subscriptions & Promotions	4,394	0	0	0	0	0	0	0	0	0	0	4,394	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	1,640	0	0	0	0	0	0	0	0	0	0	1,640	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	24,200	0	0	0	0	0	0	0	0	0	0	24,200	27
28	**TOTAL General Administration**	30,254	0	0	0	0	0	0	0	0	0	0	30,254	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	30,254	0	0	0	0	0	0	0	0	0	0	30,254	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ST JOSEPH HOME OF PEORIA # 0013862 **Report Period Beginning:** 07/01/2001 **Ending:** 06/30/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	6,477	0	0	0	0	0	0	0	0	0	0	6,477	36
37	**TOTAL Ownership**	6,477	0	0	0	0	0	0	0	0	0	0	6,477	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	36,731	0	0	0	0	0	0	0	0	0	0	36,731	45

Facility Name & ID Number ST JOSEPH HOME OF PEORIA # 0013862 Report Period Beginning: 07/01/2001 Ending: 06/30/2002

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ST JOSEPH HOME OF PEORIA # 0013862 Report Period Beginning: 07/01/2001 Ending: 06/30/2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	NONE								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number ST JOSEPH HOME OF PEORIA # 0013862 Report Period Beginning: 07/01/2001 Ending: 6/30/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number ST JOSEPH HOME OF PEORIA # 0013862 Report Period Beginning: 07/01/2001 Ending: 06/30/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	N/A						$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number ST JOSEPH HOME OF PEORIA # 0013862 Report Period Beginning: 07/01/2001 Ending: 06/30/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	Tax Exempt	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$		2
3. Under or (over) accrual (line 2 minus line 1).	$		3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$		7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1997	8
	1998	9
	1999	10
	2000	11
	2001	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME ST JOSEPH HOME OF PEORIA COUNTY Peoria

FACILITY IDPH LICENSE NUMBER 0013862

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number ST JOSEPH HOME OF PEORIA # 0013862 Report Period Beginning: 07/01/2001 Ending: 06/30/2002

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 120,516 B. General Construction Type: Exterior Brick Frame Cement Block, Steel Number of Stories 2

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1		566,280	1950	$ 27,936	1
2					2
3	TOTALS	566,280		$ 27,936	3

Facility Name & ID Number ST JOSEPH HOME OF PEORIA # 0013862 Report Period Beginning: 07/01/2001 Ending: 06/30/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	194		1958	31-Dec-58	$ 2,132,689	$ 42,654	50	$ 42,654	$	$ 1,852,791	4
5			1979	31-Dec-79	10,889		20			10,889	5
6			2001	12-Mar-01	4,836	242	20	242		323	6
7											7
8											8
	Improvement Type**										
9	Bldg. Improvements			31-Dec-74	11,596		15			11,596	9
10	Bldg. Improvements			31-Dec-75	6,540		15			6,540	10
11	Bldg. Improvements			31-Dec-76	3,731		15			3,731	11
12	Bldg. Improvements			31-Dec-77	1,333		15			1,333	12
13	Blacktopping			31-Dec-78	35,175		15			35,175	13
14	Bldg. Improvements			31-Dec-79	23,573		10			23,573	14
15	Sealer Work			31-Dec-80	4,080		5			4,080	15
16	Convert B Wing			31-Dec-82	23,832		15			23,832	16
17	Showers, Roof			31-Dec-83	10,862		15			10,862	17
18	Bushes			31-Dec-83	1,928		5			1,928	18
19	Roofing, Firewall, Etc.			31-Dec-84	42,124		15			42,124	19
20	Phone System			31-Dec-84	7,600		10			7,600	20
21	Roofing, Plumbing, Tile			31-Dec-85	60,141		15			60,141	21
22	Misc. Building Improvement			31-Dec-86	124,144	4,141	15	4,141		124,144	22
23	Misc. Building Improvement			31-Dec-87	152,500	10,167	15	10,167		147,423	23
24	Bldg. Improvements			31-Dec-88	21,760	1,451	15	1,451		19,588	24
25	Parking Lot			31-Dec-88	6,334		5			6,334	25
26	Carpeting			31-Dec-89	1,391		10			1,391	26
27	Lights, Poles, Install			31-Dec-89	4,809	321	15	321		3,852	27
28	Replace Water Heaters			31-Dec-89	36,519	2,445	15	2,435	(10)	29,220	28
29	Misc. Building Improvement			31-Dec-90	24,321	1,621	15	1,621		18,642	29
30	Misc. Building Improvement			31-Dec-90	5,218		10			5,218	30
31	Bathroom Remodel			31-Dec-91	5,837	389	15	389		4,084	31
32	Bathroom Remodel (2)			31-Oct-92	5,954	397	15	397		3,836	32
33	Bathroom Remodel (1)			30-Sep-92	3,833	256	15	256		2,495	33
34	Install Showers (2)			30-Sep-92	4,556	304	15	304		2,963	34
35	Replace Doors			28-Feb-93	2,195	146	15	146		1,363	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number ST JOSEPH HOME OF PEORIA # 0013862 Report Period Beginning: 07/01/2001 Ending: 06/30/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Beauty Shop Improvements	1-Jun-94	$ 1,296	$ 86	15	$ 86	$	$ 695	37
38	Photo Eye & Lamp	1-Jun-94	2,185	146	15	146		1,180	38
39	Asbestos Removal	30-Jun-90	19,985		18	1,110	1,110	13,321	39
40	Sodium Lights	14-Feb-95	3,505	234	15	234		1,735	40
41	Remodel Showers	31-Aug-95	13,703	914	15	914		5,941	41
42	Alarm System	1-Jul-96	3,103	443	7	443		2,658	42
43	Carpet	30-Jan-97	500	71	7	71		385	43
44	Roof	9-Dec-97	90,018	9,002	10	9,002		41,259	44
45	Asbestos Removal & Plumbing	29-Nov-97	18,500	925	20	925		4,240	45
46	Asbestos Removal & Plumbing	17-Apr-98	19,800	990	20	990		4,125	46
47	Lamps	9-Dec-97	16,817	2,402	7	2,402		10,927	47
48	Windows	31-Aug-98	1,903	95	20	95		372	48
49	New Sewer Line to Grease Pit	28-Feb-99	1,730	173	10	173		591	49
50	New Pipes & Repairs	31-Mar-99	839	84	10	84		280	50
51	Tiles & Flooring	20-Apr-99	1,950	195	10	195		634	51
52	Alarm System	30-Apr-99	13,729	915	15	915		2,974	52
53	Pave Parking Lot	25-May-99	64,959	8,120	8	8,120		25,713	53
54	Remove Wall & Put in Door	2-Nov-98	1,050	70	15	70		257	54
55	Remove Wall & Put in Door	24-Mar-99	1,350	90	15	90		300	55
56	Sidewalks	3-Jun-99	4,440	296	15	296		912	56
57	Parker Bath with Electric Adjustments	17-Jan-00	8,900	890	10	890		2,225	57
58	Lath & Plaster Repairs	29-Jan-00	1,536	154	10	154		385	58
59	Bath Remodel	5-Jan-00	877	88	10	88		220	59
60	Light Fixtures	17-Mar-00	413	41	10	41		96	60
61	Tile Repair in Washtub Area	4-Apr-00	1,369	137	10	137		308	61
62	Carpet	19-Jun-00	659	66	10	66		137	62
63	Carpet	31-Jan-00	525	52	10	52		130	63
64	4' x 8' Two-sided Sign & Posts	17-Jan-00	1,800	180	10	180		450	64
65	Sidewalks	1-Jun-00	2,200	147	15	147		306	65
66	Asbestos Removal	15-Sep-00	12,500	625	20	625		1,146	66
67	Fixtures	31-Oct-00	9,291	929	10	929		1,548	67
68	Carpet	31-May-01	705	70	10	70		76	68
69	Wrought Iron Fence and Gates	8-Aug-00	1,175	78	15	78		150	69
70	TOTAL (lines 4 thru 69)		$ 3,103,612	$ 93,242		$ 94,342	$ 1,100	$ 2,592,747	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ST JOSEPH HOME OF PEORIA # 0013862 Report Period Beginning: 07/01/2001 Ending: 06/30/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,103,612	$ 93,242		$ 94,342	$ 1,100	$ 2,592,747	1
2	Fire Alarm System	12-Oct-01	11,850	593	15	593		593	2
3	Fire Alarm System	20-Nov-01	5,388	210	15	210		210	3
4	Light Fixtures	1-Feb-02	1,171	49	10	49		49	4
5	Ventilators	3-Jul-01	7,987	532	15	532		532	5
6	Carpet	21-Nov-01	1,200	70	10	70		70	6
7	Carpet	13-Sep-01	707	59	10	59		59	7
8	Carpet	12-Dec-01	800	47	10	47		47	8
9	Plaster Work	11-Jan-02	166	8	10	8		8	9
10	Plaster Work	23-Nov-01	877	51	10	51		51	10
11	Ceramic Tile Work	25-Apr-02	1,000	17	10	17		17	11
12	Sewer & Pipe Repair	30-Apr-02	20,698	345	10	345		345	12
13	C Wing Roof Repair	14-Mar-02	3,277	73	15	73		73	13
14	Linoleum Floor	10-Apr-02	1,080	27	10	27		27	14
15	Carpet	24-Apr-02	732	12	10	12		12	15
16	Roof Repairs	30-Apr-02	2,388	27	15	27		27	16
17	Bathroom Plastering	3-May-02	531	9	10	9		9	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,163,464	$ 95,371		$ 96,471	$ 1,100	$ 2,594,876	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ST JOSEPH HOME OF PEORIA # 0013862 Report Period Beginning: 07/01/2001 Ending: 06/30/2002

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 273,772	$ 29,597	$ 29,597	$	5 to 10	$ 179,557	71
72	Current Year Purchases	24,273	2,164	2,164		5 to 10	2,164	72
73	Fully Depreciated Assets	479,988					479,988	73
74								74
75	TOTALS	$ 778,033	$ 31,761	$ 31,761	$		$ 661,709	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Long-Term Care	Chevy Truck - 1985	31-Dec-91	$ 9,042	$	$	$		$ 9,042	76
77	Long-Term Care	Chevy Lumina - 1993	17-Aug-95	15,202					15,202	77
78	Long-Term Care	Ford Escort - 1997	18-Jul-96	15,279	254	254			15,279	78
79										79
80	TOTALS			$ 39,523	$ 254	$ 254	$		$ 39,523	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,008,956	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 127,386	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 128,486	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 1,100	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,296,108	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Retired Sisters Convent	$ 288,400	$ 7,210	$ 219,905	86
87	Working Sisters Housed in Home				87
88	Portion of Depreciation		5,040		88
89	Carpeting in Retired Sisters Convent	2,964	371	1,391	89
90					90
91	TOTALS	$ 291,364	$ 12,621	$ 221,296	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number ST JOSEPH HOME OF PEORIA # 0013862 Report Period Beginning: 07/01/2001 Ending: 06/30/2002

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	N/A			$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number ST JOSEPH HOME OF PEORIA # 0013862 Report Period Beginning: 07/01/2001 Ending: 06/30/2002

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

We hire only certified aides.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	N/A	hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number ST JOSEPH HOME OF PEORIA **#** 0013862 **Report Period Beginning:** 07/01/2001 **Ending:** 06/30/2002

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 06/30/2002 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 190,764	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	147,418		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	32,510		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Deferred Expense S/T	1,540		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 372,232	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	945,240		12
13	Land	153,532		13
14	Buildings, at Historical Cost	3,304,191		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	847,299		16
17	Accumulated Depreciation (book methods)	(3,504,732)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	545,356		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Deferred Expense L/T	8,119		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,299,005	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,671,237	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 74,734	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	84,545		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 159,279	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 159,279	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,511,958	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,671,237	$	48

***(See instructions.)**

Facility Name & ID Number ST JOSEPH HOME OF PEORIA # 0013862 Report Period Beginning: 07/01/2001 Ending: 06/30/2002

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,265,531	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,265,531	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(753,573)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (753,573)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,511,958	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number ST JOSEPH HOME OF PEORIA # 0013862 Report Period Beginning: 07/01/2001 Ending: 06/30/2002

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,192,560	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,192,560	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	39,746	12
13	Barber and Beauty Care	3,135	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio	30	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	125	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 43,036	23
	D. Non-Operating Revenue		
24	Contributions	100,352	24
25	Interest and Other Investment Income***	(189,514)	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ (89,162)	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Sisters' Maintenance & Chapel	380,611	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 380,611	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,527,045	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,523,750	31
32	Health Care	1,885,907	32
33	General Administration	651,461	33
	B. Capital Expense		
34	Ownership	134,963	34
	C. Ancillary Expense		
35	Special Cost Centers	60,994	35
36	Provider Participation Fee	23,543	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,280,618	40
41	**Income before Income Taxes (line 30 minus line 40)****	(753,573)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (753,573)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number ST JOSEPH HOME OF PEORIA # 0013862 Report Period Beginning: 07/01/2001 Ending: 06/30/2002

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,326	2,486	$ 54,092	$ 21.76	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,440	7,001	101,581	14.51	3
4	Licensed Practical Nurses	29,802	32,371	445,583	13.76	4
5	Nurse Aides & Orderlies	55,588	60,910	571,102	9.38	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,867	2,086	22,193	10.64	8
9	Activity Director	1,915	2,091	21,057	10.07	9
10	Activity Assistants	3,861	3,974	28,451	7.16	10
11	Social Service Workers	1,037	1,045	11,447	10.95	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	5,988	6,695	88,397	13.20	17
18	Housekeepers	35,744	40,137	340,095	8.47	18
19	Laundry					19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative	1,819	1,947	24,187	12.42	22
23	Office Manager					23
24	Clerical	4,819	4,890	45,670	9.34	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Snack Bar Worker	1,736	1,988	17,532	8.82	33
34	TOTAL (lines 1 - 33)	152,942	167,621	$ 1,771,387 *	$ 10.57	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	4	400	L 9	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	22	1,036	L 100	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	32	1,103	L 11	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	58	$ 2,539		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	193	$ 5,917	L 10; C 3	50
51	Licensed Practical Nurses	3,714	108,193	L 10; C3	51
52	Nurse Aides	5,987	101,175	L 10; C 3	52
53	TOTAL (lines 50 - 52)	9,894	$ 215,285		53

Facility Name & ID Number ST JOSEPH HOME OF PEORIA # 0013862 Report Period Beginning: 07/01/2001 Ending: 06/30/2002

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$

B. Administrative - Other

Description	Amount
Sister Mary Dries, Co-Administrator	$ 36,814
Sister Mary Paul Mazzorana, Co-Administrator	28,303
TOTAL (agree to Schedule V, line 17, col. 3)	$ 65,117
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Ginoli & Co.	Accountants	$ 9,460
Clifton Gunderson	Computer Services	3,713
Dieter Kiefer	Computer Services	50
Micro-Ram Computers	Computer Services	275
Honkamp Krueger & Nat'l City	Payroll & Bank Charges	5,657
Heyl Royster	Lawyers	20
Bank-Koe System	Timekeeping	1,436
Phillip Swager	Architects	1,110
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 21,721

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 57,345
Unemployment Compensation Insurance	
FICA Taxes	138,415
Employee Health Insurance	112,438
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Professional Liability	16,223
TOTAL (agree to Schedule V, line 22, col.8)	$ 324,421

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	1,714
Health Care Worker Background Check	276
(Indicate # of checks performed 23)	
Yellow Pages Ad & Advertising	9,965
State Licenses	486
INHAA, Ciata, DON Association Dues	170
Sam's Club	30
Peoria City/County Public Health Dept.	150
Notary Express/CLIA	200
Less: Public Relations Expense	( )
Non-allowable advertising	(7,285)
Yellow page advertising	(4,394)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 1,312

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	18
Seminar Expense	1,329
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,347

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number ST JOSEPH HOME OF PEORIA # 0013862 Report Period Beginning: 07/01/2001 Ending: 06/30/2002

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	Repair Temp Cntrl	04 Sep 98	$ 784	5	$ 131	$ 157	$ 157	$ 157	$	$	$	$	$
2	Tree Removal & Trim	22 Sep 98	1,750	3	486	583	583	98					
3	Repair Roof	30 Nov 98	2,162	3	481	721	721	239					
4	Repair Roof	31 Mar 99	3,230	3	359	1,077	1,077	717					
5	Plaster Repair	03 Apr 99	9,698	10	242	970	970	970					
6	Repair Heat Exchange	28 Apr 99	651	3	54	217	217	163					
7	Plumbing Repairs	31 Aug 99	4,137	10		379	414	414					
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 22,412		$ 1,753	$ 4,104	$ 4,139	$ 2,758	$	$	$	$	$

Facility Name & ID Number # Report Period Beginning: 07/01/2001 Ending: 06/30/2002

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **INHAA $75.00**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **Yes** If YES, what is the capacity? **187**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **12**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **15,935** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **23,543**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **Yes** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **N/A**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **Yes** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? _____ Indicate the amount. $ _____

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **7%**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.